FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0006353

Facility Name: Apostolic Christian Skylines

Address: 7023 NE Skyline Drive (Number) | Peoria (City) | 61614 (Zip Code)

County: Peoria

Telephone Number: 309-691-8091 **Fax #** 309-683-2505

IDPA ID Number: 370716056002

Date of Initial License for Current Owners: 08/12/1966

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501(c)3		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Roger D. Herman **Telephone Number:** 309-691-8091

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Roger D. Herman

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	14	Skilled (SNF)	14	5,124	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	43	Intermediate (ICF)	43	15,738	3
4	0	Intermediate/DD	0	0	4
5	29	Sheltered Care (SC)	29	10,614	5
6	0	ICF/DD 16 or Less	0	0	6
7	86	TOTALS	86	31,476	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,160	2,649	667	4,476	8
9	SNF/PED					9
10	ICF	4,344	10,563	83	14,990	10
11	ICF/DD					11
12	SC	1,366	7,110	0	8,476	12
13	DD 16 OR LESS					13
14	TOTALS	6,870	20,322	750	27,942	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.77%

D. How many bed-hold days during this year were paid by Public Aid?
2 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals, Housekeeping, Groundskeeping

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/12/1966

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 646

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 2000 Fiscal Year: 2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	193,961	13,702	75	207,738	(7,750)	199,988	(6,300)	193,688			1
2	Food Purchase		134,861		134,861	(7,750)	127,111	(6,300)	120,811			2
3	Housekeeping	59,770	15,394		75,164		75,164	(636)	74,528			3
4	Laundry	39,688	5,994		45,682		45,682		45,682			4
5	Heat and Other Utilities			93,240	93,240		93,240	(15,385)	77,855			5
6	Maintenance	72,403	34,567	17,391	124,361		124,361	(3,821)	120,540			6
7	Other (specify):*		5,232		5,232		5,232	(262)	4,970			7
8	**TOTAL General Services**	365,822	209,750	110,706	686,278	(15,500)	670,778	(32,704)	638,075			8
	B. Health Care and Programs											
9	Medical Director			32	32	(32)						9
10	Nursing and Medical Records	1,285,002	77,407	916	1,363,325	(276)	1,363,049		1,363,049			10
10a	Therapy			74,809	74,809		74,809		74,809			10a
11	Activities	83,607	1,729	300	85,636		85,636		85,636			11
12	Social Services	47,682		798	48,480		48,480		48,480			12
13	Nurse Aide Training					105	105		105			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,416,291	79,136	76,855	1,572,282	(203)	1,572,079		1,572,079			16
	C. General Administration											
17	Administrative	112,557			112,557		112,557		112,557			17
18	Directors Fees											18
19	Professional Services			9,499	9,499	32	9,531		9,531			19
20	Dues, Fees, Subscriptions & Promotions			29,015	29,015	(90)	28,925	(479)	28,446			20
21	Clerical & General Office Expenses	69,864	29,482	18,676	118,022	306	118,328	(4,347)	113,981			21
22	Employee Benefits & Payroll Taxes			383,323	383,323	15,455	398,778	(9,972)	388,806			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,039	12,039		12,039		12,039			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			20,422	20,422		20,422	(2,451)	17,971			26
27	Other (specify):*											27
28	**TOTAL General Administration**	182,421	29,482	472,974	684,877	15,703	700,580	(17,249)	683,331			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,964,534	318,368	660,535	2,943,437		2,943,437	(49,953)	2,893,485			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

Explanation of Reclassification (Column 5)

1. An attorney bill for $ 32.00 was incorrectly posted to the medical director consultation.
2. General office expenses worth $ 276.00 was incorrectly posted to medical records consultation.
3. An employee benefit of $ 60.00 paid to an employee was incorrectly posted to Dues and Subscription.
4. A general office expense of $ 30.00 was incorrectly posted to Dues and Subscription.
5. Dietary and food expenses of $ 15,500.00 was for meal discounts to employees.
6. CNA training expense of $ 105.00 was posted as an employee benefit.

Facility Name & ID Number Apostolic Christian Skylines #0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			138,383	138,383		138,383	(26,926)	111,457			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,400	2,400		2,400	(2,400)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			140,783	140,783		140,783	(29,326)	111,457			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			136,349	136,349		136,349		136,349			39
40	Barber and Beauty Shops			9,825	9,825		9,825		9,825			40
41	Coffee and Gift Shops			5,356	5,356		5,356		5,356			41
42	Provider Participation Fee			31,294	31,294		31,294		31,294			42
43	Other (specify):*			1,737	1,737		1,737		1,737			43
44	**TOTAL Special Cost Centers**			184,561	184,561		184,561		184,561			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,964,534	318,368	985,879	3,268,781		3,268,781	(79,279)	3,189,503			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,600)	1, 2		4
5	Telephone, TV & Radio in Resident Rooms	(4,347)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(2,400)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(479)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(59,453)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (79,279)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (79,279)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Apostolic Christian Skylines

ID# 0006353

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Care Heat and Other Utilities	$ (15,385)	5	1
2	Non-Care Maintenance	(3,821)	6	2
3	Non-Care Security and Disposal	(262)	7	3
4	Non-Care Employee Benefits and Payroll Taxes	(9,972)	22	4
5	Non-Care Insurance-Prop. Liab. And Malpractice	(2,451)	26	5
6	Non-Care Housekeeping	(636)	3	6
7	Non-Care Depreciation	(28,470)	30	7
8	Straight-Line Depreciation Adjustment	1,544	30	8
9				9
10				10
11				11
12				12
13				13
14				14
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87				87
88				88
89				89
90	**Total**	(59,453)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(636)	0	0	0	0	0	0	0	0	0	0	(636)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(15,385)	0	0	0	0	0	0	0	0	0	0	(15,385)	5
6	Maintenance	(3,821)	0	0	0	0	0	0	0	0	0	0	(3,821)	6
7	Other (specify):*	(262)	0	0	0	0	0	0	0	0	0	0	(262)	7
8	**TOTAL General Services**	(20,104)	0	0	0	0	0	0	0	0	0	0	(20,104)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(479)	0	0	0	0	0	0	0	0	0	0	(479)	20
21	Clerical & General Office Expenses	(4,347)	0	0	0	0	0	0	0	0	0	0	(4,347)	21
22	Employee Benefits & Payroll Taxes	(9,972)	0	0	0	0	0	0	0	0	0	0	(9,972)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,451)	0	0	0	0	0	0	0	0	0	0	(2,451)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(17,249)	0	0	0	0	0	0	0	0	0	0	(17,249)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(37,353)	0	0	0	0	0	0	0	0	0	0	(37,353)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Apostolic Christian Skylines **#** 0006353 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(26,926)	0	0	0	0	0	0	0	0	0	0	(26,926)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,400)	0	0	0	0	0	0	0	0	0	0	(2,400)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(29,326)	0	0	0	0	0	0	0	0	0	0	(29,326)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(66,679)	0	0	0	0	0	0	0	0	0	0	(66,679)	45

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,100 B. General Construction Type: Exterior Brick Frame Steel / Masonary Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Storage and Maintenance, 4,650 Sq. Ft.
Apartments, 18,850 Sq. Ft., 18 Units
Duplexes, 1,150 Sq. Ft. / Unit, 14 Units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	For Nursing Home	200,000	1964	$ 743	1
2					2
3	TOTALS	200,000		$ 743	3

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	29		1966	1965	$ 348,310	$ 6,966	50	$ 6,966	$	$ 252,242	4
5	21		1971	1971	396,963	7,939	50	7,939		257,475	5
6	16		1985	1985	750,000	15,000	50	15,000		232,500	6
7	3		1989	1988	205,070	4,101	50	4,101		48,906	7
8			1995	1995	870,388	17,408	50	17,408		104,448	8
	Improvement Type**										
9	17			1996	793,538	15,871	50	15,871		79,355	9
10	Room Remodel of 1966 Building			1974	6,594	132	50	132		3,497	10
11	Fire Sprinkler System for 1971 Building			1977	23,804	476	50	476		12,272	11
12	Dining Room Addition to 1966 Building			1978	38,922	778	50	778		17,524	12
13	Fird Sprinkler System for 1966 Building			1979	35,330	707	50	707		15,338	13
14	Window Replacement for 1966 Building			1981	23,820	476	50	476		9,415	14
15	Kitchen Remodel of 1966 Building			1982	21,631	433	50	433		8,124	15
16	Energy Management System, Cabinets, Water Heaters, Em. Gen.			1983	8,413	168	50	168		2,856	16
17	Room Remodel of 1966 Building			1984	7,742	155	50	155		2,635	17
18	Storage Cabinets			1986	1,618	32	50	32		480	18
19	Air Conditioning Replacement 1966 Building			1987	6,427	129	50	129		597	19
20	New Physical Therapy Department 1966 Building			1989	11,503	230	50	230		2,732	20
21	Office Addition to 1966 Building			1991	50,297	1,006	50	1,006		9,132	21
22	New Roof to 1966 Building			1993	14,210	284	50	284		2,272	22
23	Room Remodel of 1966 Building			1994	5,154	103	50	103		721	23
24	Front Entry Canopy, Office Remodel, Back Hall Coiling 1966 Building			1996	62,294	1,246	50	1,246		7,104	24
25	Rear Gutter Facia, Remodel Utility and Laundry Room 1971 Building			1996	89,096	1,782	50	1,782		8,910	25
26	Fence, Front Soffit, Auto Front Door: 1966 Building			1997	28,036	561	50	561		2,383	26
27	Remodel Physical Therapy, Employee Lounge, Social Services			1998	88,061	1,761	50	1,761		5,259	27
28	Door Alarms Throughout the Building			2000	4,978	100	50	100		100	28
29	Remodel Throughout the Building			2000	110,832	62	50	2,217	2,155	2,217	29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 4,003,031	$ 77,906		$ 80,061	$ 2,155	$ 1,088,494	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 515,742	$ 25,787	$ 25,787	$	20	$ 153,609	37
38	Current Year Purchases	98,792				20		38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 614,534	$ 25,787	$ 25,787	$		$ 153,609	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Transportation	Ford Bus 1999	1999	$ 58,988	$ 6,220	$ 5,899	$ (321)	10	$ 12,220	42
43	Maintenance	John Deere 950	1979	4,400				20	4,040	43
44										44
45										45
46	TOTALS			$ 63,388	$ 6,220	$ 5,899	$ (321)		$ 16,260	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,681,696	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 109,913	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 111,747	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 1,834	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,258,363	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Buildings Non Care - 1978, 85, 86	$ 1,334,748	$ 25,438	$ 536,615	52
53	Equipment Non-Care - 1988, 97, 00	47,251	952	11,948	53
54	Vehicles Non-Care - 1985, 87, 99	28,450	2,080	12,360	54
55	Land Non-Care 1973,78	112,446			55
56					56
57	TOTALS	$ 1,522,895	$ 28,470	$ 560,923	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments			105		105
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 105	$	$ 105
10	SUM OF line 9, col. 1 and 2	(e)	$ 105			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a - 3	hrs	$	52	$ 3,565	$	52	$ 3,565	1
2	Licensed Speech and Language Development Therapist	10a - 3	hrs		20	1,773		20	1,773	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a - 3	hrs		85	6,015		85	6,015	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				131,537		131,537	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	157	$ 11,353	$ 131,537	157	$ 142,890	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 24,174	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	230,247		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	9,161		5
6	Prepaid Insurance	20,233		6
7	Other Prepaid Expenses	8,335		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 292,150	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	765,332		12
13	Land	113,189		13
14	Buildings, at Historical Cost	5,323,284		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	753,624		16
17	Accumulated Depreciation (book methods)	(1,817,131)		17
18	Deferred Charges	14,495		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	848,958		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,001,751	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,293,901	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 47,271	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	48,429		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,811		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Insurance, Vacation, etc.	56,265		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 172,776	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Contingent Payable	260,988		43
44	Duplex Insurance	18,801		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 279,789	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 452,565	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,841,336	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,293,901	$	48

***(See instructions.)**

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,680,555	1
2	Restatements (describe):		2
3	Correction of Asset accounts to correspond to audited numbers	7,007	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,687,562	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	153,774	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 153,774	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,841,336	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,657,273	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,657,273	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	11,755	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 11,755	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	6,838	12
13	Barber and Beauty Care	9,633	13
14	Non-Patient Meals	23,520	14
15	Telephone, Television and Radio	13,847	15
16	Rental of Facility Space		16
17	Sale of Drugs	134,882	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 188,720	23
	D. Non-Operating Revenue		
24	Contributions	443,204	24
25	Interest and Other Investment Income***	74,988	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 518,192	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Non-Care Revenues	46,615	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 46,615	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,422,555	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	686,278	31
32	Health Care	1,572,282	32
33	General Administration	684,877	33
	B. Capital Expense		
34	Ownership	140,783	34
	C. Ancillary Expense		
35	Special Cost Centers	153,267	35
36	Provider Participation Fee	31,294	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,268,781	40
41	**Income before Income Taxes (line 30 minus line 40)****	153,774	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 153,774	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,834	2,069	$ 47,442	$ 22.93	1
2	Assistant Director of Nursing	1,957	2,069	41,925	20.26	2
3	Registered Nurses	15,779	16,733	281,873	16.85	3
4	Licensed Practical Nurses	14,276	15,009	220,083	14.66	4
5	Nurse Aides & Orderlies	66,648	69,974	673,281	9.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,211	3,606	35,432	9.83	9
10	Activity Assistants	6,008	6,307	48,175	7.64	10
11	Social Service Workers	3,088	3,228	47,682	14.77	11
12	Dietician					12
13	Food Service Supervisor	2,028	2,038	32,527	15.96	13
14	Head Cook	1,176	1,563	16,803	10.75	14
15	Cook Helpers/Assistants	13,176	14,128	117,580	8.32	15
16	Dishwashers	3,689	3,689	27,051	7.33	16
17	Maintenance Workers	6,036	6,445	72,403	11.23	17
18	Housekeepers	7,170	7,620	59,770	7.84	18
19	Laundry	5,057	5,417	39,688	7.33	19
20	Administrator	1,897	1,997	63,796	31.95	20
21	Assistant Administrator	1,767	1,955	48,761	24.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,233	6,648	69,864	10.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,265	2,472	20,398	8.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,295	172,967	$ 1,964,534 *	$ 11.36	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant	16	640	10 - 3 & 5	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	300	11 - 3	44
45	Social Service Consultant	20	798	12 - 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	42	$ 1,738		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$		50
51	Licensed Practical Nurses	0			51
52	Nurse Aides	0			52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Roger D. Herman	Administrator	0	$ 63,796
Richard L. Plattner	Asst. Admin.	0	48,761
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 112,557

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Westervelt, Johnson, Nicoll, Keller	Attorneys	$ 6,380
Apostolic Christian Restmor	CPA	1,520
PSA Architects	Architects	1,631
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 9,531

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 13,356
Unemployment Compensation Insurance	8,158
FICA Taxes	151,899
Employee Health Insurance	132,296
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical	4,623
401K Retirement Plan	49,604
Misc. Incentives	22,613
Uniforms	834
Employee Meal Discounts	15,500
Non-Care Benefits	(9,972)
TOTAL (agree to Schedule V, line 22, col.8)	$ 388,911

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	22,316
Health Care Worker Background Check	
(Indicate # of checks performed 33)	462
Life Services Network	3,500
Misc. Publications	1,000
Employer's Association	490
Journal Star	678
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,446

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,234
In-State Travel	2,932
Seminar Expense	5,873
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,039

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSNI, ALFA**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **20 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,205** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **31,294**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **15,500** Has any meal income been offset against related costs? **No** Indicate the amount. $ **4,435**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes - Those that are care related**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees